		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032904

Facility Name: Manorcare at Libertyville

Address: 1500 South Milwaukee Avenue (Number) Libertyville (City) 60048 (Zip Code)

County: Lake

Telephone Number: (708) 816-3200 **Fax #** (708) 816-8981

HFS ID Number: 520886946009

Date of Initial License for Current Owners: 02/02/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2004 to 05/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,318	4,420	12,256	37,994	8
9	SNF/PED					9
10	ICF	3,250			3,250	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,568	4,420	12,256	41,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.33%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/23/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 9,532

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Libertyville # 0032904 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	325,070	20,973	4,111	350,154	2,846	353,000		353,000			1
2	Food Purchase		216,461		216,461		216,461	(2,725)	213,736			2
3	Housekeeping	128,696	17,818	1,262	147,776		147,776		147,776			3
4	Laundry	34,309	24,684	621	59,614		59,614	(270)	59,344			4
5	Heat and Other Utilities			161,789	161,789	6,565	168,354	(4,795)	163,559			5
6	Maintenance	48,033	15,614	123,436	187,083		187,083		187,083			6
7	Other (specify):* **Med. Waste**			2,808	2,808		2,808		2,808			7
8	**TOTAL General Services**	536,108	295,550	294,027	1,125,685	9,411	1,135,096	(7,790)	1,127,306			8
	B. Health Care and Programs											
9	Medical Director			33,600	33,600		33,600		33,600			9
10	Nursing and Medical Records	2,418,161	192,569	396,043	3,006,773	48,540	3,055,313	(1,622)	3,053,691			10
10a	Therapy	349,692	18,483	239,405	607,580		607,580		607,580			10a
11	Activities	95,300	4,492	1,588	101,380		101,380		101,380			11
12	Social Services	91,174		2,596	93,770		93,770		93,770			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,954,327	215,544	673,232	3,843,103	48,540	3,891,643	(1,622)	3,890,021			16
	C. General Administration											
17	Administrative	67,954		597,844	665,798	(338,685)	327,113		327,113			17
18	Directors Fees											18
19	Professional Services			50,442	50,442	(1,139)	49,303	(49,303)				19
20	Dues, Fees, Subscriptions & Promotions			97,868	97,868		97,868	(25,411)	72,457			20
21	Clerical & General Office Expenses	240,320	46,180	45,394	331,894	1,139	333,033	(29,933)	303,100			21
22	Employee Benefits & Payroll Taxes			758,163	758,163	44,626	802,789		802,789			22
23	Inservice Training & Education			5,122	5,122		5,122		5,122			23
24	Travel and Seminar			10,598	10,598		10,598		10,598			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			156,019	156,019		156,019		156,019			26
27	Other (specify):*											27
28	**TOTAL General Administration**	308,274	46,180	1,721,450	2,075,904	(294,059)	1,781,845	(104,647)	1,677,198			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,798,709	557,274	2,688,709	7,044,692	(236,108)	6,808,584	(114,059)	6,694,525			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Libertyville #0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			404,813	404,813	19,409	424,222		424,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,692	40,692	216,699	257,391		257,391			32
33	Real Estate Taxes			123,641	123,641		123,641	(3,458)	120,183			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			163,234	163,234		163,234		163,234			35
36	Other (specify):* G/L Assets Eq Ern			6,554	6,554		6,554		6,554			36
37	**TOTAL Ownership**			738,934	738,934	236,108	975,042	(3,458)	971,584			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		351,926	42,436	394,362		394,362		394,362			39
40	Barber and Beauty Shops		408	19,290	19,698		19,698		19,698			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* See Attached Schedule		80,106		80,106		80,106		80,106			43
44	**TOTAL Special Cost Centers**		432,440	143,851	576,291		576,291		576,291			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,798,709	989,714	3,571,494	8,359,917		8,359,917	(117,517)	8,242,400			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,725)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,795)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(270)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,622)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(49,303)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,730)	21		24
25	Fund Raising, Advertising and Promotional	(25,411)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,458)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(203)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (117,517)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,517)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare at Libertyville

ID# 0032904

Report Period Beginning: 06/01/2004

Ending: 05/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (203)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(203)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Libertyville # 0032904 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,725)	0	0	0	0	0	0	0	0	0	0	(2,725)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(270)	0	0	0	0	0	0	0	0	0	0	(270)	4
5	Heat and Other Utilities	(4,795)	0	0	0	0	0	0	0	0	0	0	(4,795)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,790)	0	0	0	0	0	0	0	0	0	0	(7,790)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,622)	0	0	0	0	0	0	0	0	0	0	(1,622)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,622)	0	0	0	0	0	0	0	0	0	0	(1,622)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(49,303)	0	0	0	0	0	0	0	0	0	0	(49,303)	19
20	Fees, Subscriptions & Promotions	(25,411)	0	0	0	0	0	0	0	0	0	0	(25,411)	20
21	Clerical & General Office Expenses	(29,933)	0	0	0	0	0	0	0	0	0	0	(29,933)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(104,647)	0	0	0	0	0	0	0	0	0	0	(104,647)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(114,059)	0	0	0	0	0	0	0	0	0	0	(114,059)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Libertyville** **#** **0032904** **Report Period Beginning:** **06/01/2004** **Ending:** **05/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(3,458)	0	0	0	0	0	0	0	0	0	0	(3,458)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,458)	0	0	0	0	0	0	0	0	0	0	(3,458)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(117,517)	0	0	0	0	0	0	0	0	0	0	(117,517)	45

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp.	Toledo, Ohio			
		of America				
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See	Home Office Cost	$ 597,844	HCR ManorCare, Inc.	100.00%	$ 597,844	$	1
2	V		Page							2
3	V		8							3
4	V									4
5	V									5
6	V		10a	Therapy Management	25,062	Heartland Management Services	100.00%	25,062		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 622,906			$ 622,906	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 5/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: ((419) - 252-5500
Fax Number: ((419) - 252-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	$	$	7,717,838	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	7,717,838	2,846	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		7,717,838	730	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		7,717,838	5,835	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	7,717,838	42,396	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	7,717,838	6,144	6
7	17	General & Administrative - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	7,717,838	54,227	7
8	17	General & Administrative - Poole	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	7,717,838	204,932	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		7,717,838	12,811	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		7,717,838	31,815	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.			7,717,838	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		7,717,838	19,409	12
13										13
14	32	Interest				10,002,527			216,699	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 597,844	25

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 3,244,133	$ 3,244,133			$ 216,699	1
2	National City Bank, Trustee						650,995	650,995			40,692	2
3												3
4												4
5	Interest Expense Other											5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,895,128	$ 3,895,128			$ 257,391	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,895,128	$ 3,895,128			$ 257,391	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Libertyville **#** 0032904 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	127,683	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	124,225	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,458)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	123,641	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	120,183	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	136,241	8
	2001	69,625	9
	2002	142,408	10
	2003	133,244	11
	2004	123,641	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Libertyville COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0032904

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) - 252-5740 FAX #: (419) - 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-28-401-003	See Attached	$ 61,820.52	$ 61,820.52
2.	11-28-401-003	See Attached	$ 61,820.52	$ 61,820.52
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 123,641.04	$ 123,641.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,902 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 476,076	1
2			2000	9,118	2
3	TOTALS			$ 485,194	3

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150			1988	$ 4,592,131	$ 117,248		$ 117,248	$	$ 1,928,547	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					176,829		176,829		1,451,951	9
10				1988	68,073						10
11				1989	52,434						11
12				1990	30,247						12
13				1991	67,316						13
14				1992	175,480						14
15	RETIREMENTS			1992	(10,437)						15
16				1993	55,746						16
17				1994	135,262						17
18				1995	66,532						18
19	FLOOR VINYL/TILE & INSTALLATION			1996	31,353						19
20	CAPITALIZED LABOR-NURSES STATION RENOV			1996	7,272						20
21	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR			1996	(7,272)						21
22	WALLVINYL/SIGNS			1996	5,576						22
23	CARPET			1996	4,210						23
24	INNER CAMERA MONITOR			1996	4,177						24
25	SIDING			1996	2,205						25
26	REPAIR LOOSE BRICKS			1996	2,183						26
27	NURSES STATION RENOVATION			1996	11,271						27
28	DOOR RELEASE			1996	2,071						28
29	REMODELING			1996	1,129						29
30	WATER HEATER			1996	5,313						30
31	CARPET/INSTALLATION			1996	2,991						31
32	FLOORING/TILE			1996	23,312						32
33	DOOR FRAME/GUARDS			1996	4,941						33
34	KITCHEN CELING TILE			1996	3,638						34
35	WALLCOVERINGS			1996	4,964						35
36	ELECTRICAL/LIGHTING			1996	3,055						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CABINETRY	1996	$ 5,880	$		$	$	$	37
38	REBUILD NURSES STATION	1996	8,500						38
39	INSTALL SWING DOORS	1996	8,826						39
40	INSTALL BALLUSTER POSTS	1996	2,500						40
41	FLOOR COVING	1996	7,791						41
42	BRICK PIER/CONCRETE SIDEWALK	1996	3,880						42
43	INSTALL BOULDER EDGE	1996	4,830						43
44	NURSES STATION RENOVATIONS	1996	1,506						44
45	WALLVINYL	1997	18,304						45
46	CARPETING	1997	1,624						46
47	DECORATING	1997	45,045						47
48	BRICK PIER	1997	1,500						48
49	EXTERIOR ENTRY DOORS	1997	3,317						49
50	PAINTING	1997	7,449						50
51	INSTALL CONDENSING COILS	1997	2,583						51
52	LANDSCAPE	1997	59,118						52
53	CURBING/ASPHALT	1997	30,000						53
54	ROOFING	1997	1,536						54
55	CORPORATE OVERHEAD-PARKING LOT	1997	10,516						55
56	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(10,516)						56
57	PARKING LOT WORK	1997	25,000						57
58	FACILITY PLAN ALLOC	1997	5,964						58
59	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(3,206)						59
60	C/R 5/31/99 AUDIT ADJ. - FAC PLAN ALLOC	1997	(2,759)						60
61	ELEVATOR REPAIRS	1997	5,018						61
62	SECURITY SYSTEM	1997	16,954						62
63	NEW EXHAUSTERS	1997	6,310						63
64	BUILD & INSTALL CABINETS	1997	6,512						64
65	CARPET	1997	5,148						65
66	LANDSCAPE	1997	25,279						66
67	CURB/ASPHALT	1997	45,210						67
68	INSTALL CEDAR FENCE	1997	2,750						68
69	DRUM SLUDGE REMOVAL	1997	2,563						69
70	TOTAL (lines 4 thru 69)		$ 5,700,105	$ 294,077		$ 294,077	$	$ 3,380,498	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,700,105	$ 294,077		$ 294,077	$	$ 3,380,498	1
2	INSTALL OIL TANK	1997	11,779						2
3	FLOORING/CEILING	1998	1,115						3
4	CARPETING	1998	2,574						4
5	ARCHITECT/PROFESSIONAL FEES-ADMIN OFFICE	1998	3,685						5
6	PAINTING/WALLPAPER	1998	10,125						6
7	RENOVATE ADMIN OFFICE	1998	2,533						7
8	ENERGY AUDITS	1998	1,875						8
9	GENERAL CONTRACTOR FEES-ADMIN OFFICE	1998	4,165						9
10	CORPORATE OVERHEAD-ADMIN OFFICE	1998	1,651						10
11	C/R 5/31/99 AUDIT ADJ - MONTHLY CAP BUDGET	1998	(1,651)						11
12	INSTALL FENCE/GAZEBO	1998	2,153						12
13	PAINTING/WALLCOVERING	1998	5,821						13
14	PLUMBING	1998	5,250						14
15	ELECTRICAL	1998	8,883						15
16	DEVELOPERS-ADMIN OFFICE	1998	5,555						16
17	SIGN	1998	11,862						17
18	ROOFING	1998	5,520						18
19	MASONARY	1998	4,766						19
20	CARPENTRY	1998	3,137						20
21	PAINTING/WALLCOVERING	1999	6,873						21
22	ELECTRICAL	1999	6,590						22
23	FLOORING/CEILING	1999	8,230						23
24	CARPENTRY	1999	12,373						24
25	MILLWORK	1999	540						25
26	FINISH STUDS	1999	20,000						26
27	PAVING	1999	35,325						27
28	CARPET FOR BUILDING	1999	11,611						28
29	WINDOW TREATMENTS	1999	10,291						29
30	KNOBLOCKS, CYPHER	1999	1,448						30
31	CARPET, CREDIT	1999	(13,990)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,890,194	$ 294,077		$ 294,077	$	$ 3,380,498	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,890,194	$ 294,077		$ 294,077	$	$ 3,380,498	1
2	SALES TAX, CARPET	1999	71						2
3	CARPET	1999	148						3
4	DOOR FRAME FOR BOILER ROOM	1999	2,550						4
5	ELECTRICAL CIRCUITS, HEATER	1999	5,937						5
6	PTAC UNITS	1999	2,920						6
7	DOOR, HARDWARE, & STAIN	2000	1,025						7
8	ADDTL COST GARAGE	2000	1,671						8
9	SECURE CARE SYS 2ND FL STAIRWELL	2000	3,147						9
10	DOOR - SOUTH CORRIDOR EXIT	2000	2,440						10
11	PANIC DEVICE - EXTERIOR DOOR	2000	760						11
12	2 A/C UNITS	2000	1,156						12
13	GARAGE	2000	21,256						13
14	LANDSCAPING	2000	2,675						14
15	LANDSCAPING - ARBORIVITAE	2000	3,784						15
16	GARAGE	2000	19,209						16
17	GARAGE	2000	5,556						17
18	BOILER	2001	4,525						18
19	FIRE WALL IN ATTIC	2001	7,422						19
20	A/C UNIT	2001	597						20
21	4 A/C UNITS	2001	2,680						21
22	WORKCOUNTER & CABINETS	2001	2,219						22
23	GATES	2001	4,760						23
24	ELECTRICAL CIRCUITS	2001	1,279						24
25	ARCADIA CORRIDORS & LOUNGE	2001	132,623						25
26	ARCADIA CORRIDORS & LOUNGE	2001	5,666						26
27	ARCADIA CORRIDORS & LOUNGE	2001	124,865						27
28	ARCADIA CORRIDORS & LOUNGE	2001	20,483						28
29	ARCADIA CORRIDORS & LOUNGE	2001	181,656						29
30	CARPENTRY, DOORS, ELECT.	2001	52,344						30
31	VWC, CORNER GUARDS	2001	10,041						31
32	DINING ROOM & BREAKROOM	2003	21,720						32
33	RETROACTIVE ADDITION	2003	(588)						33
34	TOTAL (lines 1 thru 33)		$ 6,536,792	$ 294,077		$ 294,077	$	$ 3,380,498	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,536,792	$ 294,077		$ 294,077	$	$ 3,380,498	1
2	ARCH&ENGINEER COSTS, PLANS REVIEWS	2003	16,667						2
3	GENERAL OVERHEAD & INTEREST	2003	33,439						3
4	CARPETING & PADS, WALLCOVERINGS	2003	74,310						4
5	CARPENTRY & MILLWORK	2003	5,750						5
6	HVAC & ELECTRICIAL WORK	2003	30,572						6
7	HM DOORS & FRAMES	2003	3,662						7
8	WARDROBES	2004	11,000						8
9	FLOORING	2004	761						9
10	GENERAL OVERHEAD & INTEREST	2004	32,935						10
11	SOWER ROOM RENOVATION	2004	3,000						11
12	Building décor/3 yrs Ta	2004	21						12
13	VWC	2004	252						13
14	SECOND FLOORING	2004	13,500						14
15	FRP FIRE WALL	2004	2,941						15
16	WINDOWS	2004	18,532						16
17	PAINTING EXTERIOR	2004	13,667						17
18	SHOWER ROOM RENOVATION	2004	3,800						18
19	ADD'L FLOORING	2004	1,238						19
20	SHOWER ROOM RENOVATION RE	2004	690						20
21	VWC	2004	83						21
22	RENOVATION/ 440 018 04C	2005	25,904						22
23	RENOVATION/ 440 018 04C	2005	27,234						23
24	RENOVATION/ 440 018 04C	2005	945						24
25	FLOORING	2005	1,636						25
26	INSTALL CARPET	2004	4,364						26
27	INSTALL DOORS	2005	6,480						27
28	2 LIGHT FIXTURES	2005	1,650						28
29	INSTALL SMOKE WALL & SIDE	2005	10,129						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,881,955	$ 294,077		$ 294,077	$	$ 3,380,498	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,167,414	$ 110,736	$ 110,736	$		$ 754,312	71
72	Current Year Purchases	281,491						72
73	Fully Depreciated Assets							73
74				19,409	19,409			74
75	TOTALS	$ 1,448,905	$ 110,736	$ 130,145	$ 19,409		$ 754,312	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,816,054	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 404,813	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 424,222	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,409	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,134,810	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 163,234 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3452	hrs	$ 106,500	2,686	$ 67,146	$ 1,780	6,138	$ 175,426	1
2	Licensed Speech and Language Development Therapist	10a	1503	hrs	46,372	795	19,882	909	2,298	67,163	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	6383	hrs	196,820	6,095	152,377	15,794	12,478	364,991	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				351,926		351,926	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S X-Ray, Lab, & Pod	39,3					42,436			42,436	13
14	TOTAL				$ 349,692	9,576	$ 281,841	$ 370,409	20,914	$ 1,001,942	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Manorcare at Libertyville **#** 0032904 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (11,124)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (163,288))	1,244,630		3
4	Supply Inventory (priced at)	40,137		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,011		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,280,654	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	485,194		13
14	Buildings, at Historical Cost	6,881,954		14
15	Leasehold Improvements, at Historical Cost	1,448,905		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(4,134,810)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	58,761		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,740,004	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,020,658	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,129	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,940		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,641		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	110,801		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 684,511	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	650,995		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 650,995	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,335,506	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,685,152	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,020,658	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,121,356	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,121,356	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(792,855)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (792,855)	17
	B. Transfers (Itemize):		
18		1,356,651	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,356,651	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,685,152	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,456,778	1
2	Discounts and Allowances for all Levels	(3,079,001)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,377,777	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,800,627	6
7	Oxygen	13	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,800,640	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,571	12
13	Barber and Beauty Care	22,500	13
14	Non-Patient Meals	1,154	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	342,275	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,950	19
20	Radiology and X-Ray	2,821	20
21	Other Medical Services		21
22	Laundry	270	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 388,541	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(99)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (99)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	203	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 203	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,567,062	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,125,685	31
32	Health Care	3,843,103	32
33	General Administration	2,075,904	33
	B. Capital Expense		
34	Ownership	738,934	34
	C. Ancillary Expense		
35	Special Cost Centers	576,291	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,359,917	40
41	**Income before Income Taxes (line 30 minus line 40)****	(792,855)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (792,855)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,021	2,202	$ 75,748	$ 34.40	1
2	Assistant Director of Nursing	2,333	2,541	83,566	32.89	2
3	Registered Nurses	29,065	31,660	907,570	28.67	3
4	Licensed Practical Nurses	14,867	16,194	391,518	24.18	4
5	CNAs & Orderlies	72,668	79,157	901,242	11.39	5
6	CNA Trainees					6
7	Licensed Therapist	8,454	9,126	281,569	30.85	7
8	Rehab/Therapy Aides	3,540	3,821	68,123	17.83	8
9	Activity Director					9
10	Activity Assistants	6,316	6,894	95,300	13.82	10
11	Social Service Workers	3,736	4,085	91,174	22.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,619	25,869	325,070	12.57	15
16	Dishwashers					16
17	Maintenance Workers	3,039	3,382	48,033	14.20	17
18	Housekeepers	11,035	12,042	128,696	10.69	18
19	Laundry	3,482	3,805	34,309	9.02	19
20	Administrator	1,816	2,080	67,954	32.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,961	14,224	240,320	16.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,854	4,193	58,517	13.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,806	221,275	$ 3,798,709 *	$ 17.17	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	33,600	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,400	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8,956	$ 256,769	5,10,3	50
51	Licensed Practical Nurses	2,327	56,257	5,10,3	51
52	Certified Nurse Assistants/Aides	4,391	50,010	5,10,3	52
53	TOTAL (lines 50 - 52)	15,674	$ 363,036		53

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gregory S. Seeger	Administrator	0	$ 48,067
Denise M. Dale	Administrator	0	8,991
Purchased Services	Administrator	0	10,896
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,954

B. Administrative - Other

Description	Amount
Home Office	$ 597,844
TOTAL (agree to Schedule V, line 17, col. 3)	$ 597,844
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various Vendors	Legal	$ 49,303
Rossman & Co./ Phys. Cr. Br.	Accounting	374
Carol Walters	Nursing	765
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,442

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,313
Unemployment Compensation Insurance	59,084
FICA Taxes	278,182
Employee Health Insurance	229,123
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	17,797
Employee Appreciation	8,772
Tuition Pgrm	575
Employee Uniforms	1,618
Home Office	44,626
Other Employee Benefits	83,699
TOTAL (agree to Schedule V, line 22, col.8)	$ 802,789

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 810
Advertising: Employee Recruitment	55,658
Health Care Worker Background Check	3,165
(Indicate # of checks performed 264)	
Dues & subs	599
Assoc. Dues	7,257
Advertising	30,379
Less: Lobbying Expense	(2,342)
Less: Public Relations Expense	( )
Non-allowable advertising	(23,069)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 72,457

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,598
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meegings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,598

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Libertyville # 0032904 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Manorcare at Libertyville** **#** **0032904** **Report Period Beginning:** **06/01/2004** **Ending:** **05/31/2005**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $7,257**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes. $2,342**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,896** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,154)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.